Patient _____ Identifier _____ Date _____

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 2.00

PATIENT ASSESSMENT FORM - ADMISSION

Section A Administrative Information

A0050. Type of Record

Enter Code ☐

1. **Add new assessment/record**
2. **Modify existing record**
3. **Inactivate existing record**

A0100. Facility Provider Numbers. Enter Code in boxes provided.

A. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐

B. CMS Certification Number (CCN): ☐☐☐☐☐☐☐☐☐☐☐☐

C. State Provider Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0200. Type of Provider

Enter Code ☐

3. **Long-Term Care Hospital**

A0210. Assessment Reference Date

Observation end date:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A0220. Admission Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A0250. Reason for Assessment

Enter Code ☐☐

01. **Admission**
10. **Planned discharge**
11. **Unplanned discharge**
12. **Expired**

Section A Administrative Information

Patient Demographic Information

A0500. Legal Name of Patient

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

A0600. Social Security and Medicare Numbers

A. Social Security Number: ___ – ___ – ____

B. Medicare number (or comparable railroad insurance number)**:**

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code

1. **Male**
2. **Female**

A0900. Birth Date

__ – __ – ____

Month Day Year

A1000. Race/Ethnicity

Check all that apply

- ☐ **A. American Indian or Alaska Native**
- ☐ **B. Asian**
- ☐ **C. Black or African American**
- ☐ **D. Hispanic or Latino**
- ☐ **E. Native Hawaiian or Other Pacific Islander**
- ☐ **F. White**

Section A Administrative Information

A1100. Language

Enter Code ☐

A. Does the patient need or want an interpreter to communicate with a doctor or health care staff?

0. **No** → *Skip to A1200, Marital Status*
1. **Yes** → *Specify in A1100B, Preferred language*
9. **Unable to determine** → *Skip to A1200, Marital Status*

B. Preferred language:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A1200. Marital Status

Enter Code ☐

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

A1400. Payer Information

Check all that apply

☐	**A. Medicare** (traditional fee-for-service)
☐	**B. Medicare** (managed care/Part C/Medicare Advantage)
☐	**C. Medicaid** (traditional fee-for-service)
☐	**D. Medicaid** (managed care)
☐	**E. Workers' compensation**
☐	**F. Title programs** (e.g., Title III, V, or XX)
☐	**G. Other government** (e.g., TRICARE, VA, etc.)
☐	**H. Private insurance/Medigap**
☐	**I. Private managed care**
☐	**J. Self-pay**
☐	**K. No payor source**
☐	**X. Unknown**
☐	**Y. Other**

Pre-Admission Service Use

A1802. Admitted From. Immediately preceding this admission, where was the patient?

Enter Code ☐☐

01. **Community residential setting** (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
02. **Long-term care facility**
03. **Skilled nursing facility** (SNF)
04. **Hospital emergency department**
05. **Short-stay acute hospital** (IPPS)
06. **Long-term care hospital** (LTCH)
07. **Inpatient rehabilitation facility or unit** (IRF)
08. **Psychiatric hospital or unit**
09. **ID/DD Facility**
10. **Hospice**
99. **None of the above**

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness at time of assessment.

0. **No**
1. **Yes**

Section GG Functional Status: Usual Performance

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

Code the patient's usual performance using the 6-point scale below.

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

07. **Patient refused**
09. **Not applicable**

If activity was not attempted, code:
88. Not attempted due to **medical condition or safety concerns**

Enter Codes in Boxes	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.

Section H Bladder and Bowel

H0400. Bowel Continence
(Complete during the 3-day assessment period.)

Enter Code ☐

Bowel continence - Select the one category that best describes the patient.

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** patient had an ostomy or did not have a bowel movement for the entire 3 days

Section I Active Diagnoses

For this section, indicate the presence of the following conditions, based on a review of the patient's clinical records at the time of assessment.

↓	Check all that apply
	Heart/Circulation
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Section K Swallowing/Nutritional Status

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

☐☐ inches	**A. Height** (in inches). Record most recent height measure since admission
☐☐☐ pounds	**B. Weight** (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

0. **No** → *Skip to O2500, Influenza Vaccine*
1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage*

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number ☐

A. Number of Stage 1 pressure ulcers
Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number ☐ Enter Number ☐

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

1. **Number of Stage 2 pressure ulcers -** If 0 → *Skip to M0300C, Stage 3*
2. **Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐ Enter Number ☐

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

1. **Number of Stage 3 pressure ulcers** - If 0 → *Skip to M0300D, Stage 4*
2. **Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐ Enter Number ☐

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

1. **Number of Stage 4 pressure ulcers** - If 0 → *Skip to M0300E, Unstageable: Nonremovable dressing*
2. **Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐ Enter Number ☐

E. Unstageable - Nonremovable dressing: Known but not stageable due to nonremovable dressing/device

1. **Number of unstageable pressure ulcers due to nonremovable dressing/device** - If 0 → *Skip to M0300F, Unstageable: Slough and/or eschar*
2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐ Enter Number ☐

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → *Skip to M0300G, Unstageable: Deep tissue injury*
2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number ☐ Enter Number ☐

G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution

1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → *Skip to O0250, Influenza Vaccine*
2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Section O Special Treatments, Procedures, and Programs

O0250. Influenza Vaccine - Refer to current version of LTCHQR Program Manual for current influenza season and reporting period.

Enter Code ☐

A. Did the **patient receive the influenza vaccine <u>in this facility</u>** for this year's influenza <u>vaccination</u> season?
0. **No** → *Skip to O0250C, If influenza vaccine not received, state reason*
1. **Yes** → *Continue to O250B, Date influenza vaccine received*

B. Date influenza vaccine received → *Complete date and skip to Z0400, Signature of Persons Completing the Assessment*

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If influenza vaccine not received, state reason:
1. **Patient not in this facility during this year's influenza vaccination season**
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that submitting false information may subject my organization to a 2% reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Assessment Completion

A. Signature:

B. LTCH CARE Data Set Completion Date:

		–			–				
Month			Day			Year			

PRA Disclosure Statement

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